



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Surgery Specialty Hospital of America

Respondent Name

Hartford Fire Insurance Co

MFDR Tracking Number

M4-16-1182-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

January 7, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Carrier is required to reimburse Provider \$3,449.07 pursuant to the Outpatient Fee Guideline. The Carrier made a partial payment of \$1,977.36. Therefore, the Carrier is required to reimburse Provider an additional amount of \$1,471.71, plus any and all applicable interest."

Amount in Dispute: \$1,471.97

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In reviewing the claim our investigation found that services were reimbursement per Rule 134.403 and the service does not qualify for an outlier. Based on above review, additional reimbursement is not recommended."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 1, 2015	Outpatient Hospital Services	\$1,471.97	\$1,471.97

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - P12 – Workers' compensation jurisdictional fee schedule adjustment
 - 300 – An allowance has been made for a bilateral procedure

- 802 – Charge for this procedure exceeds the OPPS schedule allowance
- 193 – Original payment decision is being maintained

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute is regarding outpatient hospital facility services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403(f)(1), which states,

The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.

(1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:

(A) 200 percent; unless

(B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.

(2) When calculating outlier payment amounts, the facility's total billed charges shall be reduced by the facility's billed charges for any item reimbursed separately under subsection (g) of this section.

Review of the submitted medical bill finds separate reimbursement for implantables is not applicable. The Maximum Allowable Reimbursement for the disputed services is calculated as follows:

- Procedure code 64479 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. These services are classified under APC 0207, which, per OPSS Addendum A, has a payment rate of \$672.06. This amount multiplied by 60% yields an unadjusted labor-related amount of \$403.24. This amount multiplied by the annual wage index for this facility of 0.9679 yields an adjusted labor-related amount of \$390.30. The non-labor related portion is 40% of the APC rate or \$268.82. The sum of the labor and non-labor related amounts is \$659.12. The provider billed this procedure code with modifier 50. Bilateral procedures are paid at the rate for two units. The highest paying status indicator T procedure is paid at 100% for the first unit; each additional T procedure unit is paid at 50%. The APC amount is \$988.68. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPSS payment and also exceeds the annual fixed-dollar threshold of \$2,775, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPSS payment. Per the OPSS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.291. This ratio multiplied by the billed charge of \$6,900.00 yields a cost of \$2,007.90. The total cost of all packaged items is allocated proportionately across all separately paid OPSS services based on the percentage of the total APC payment. The APC payment for these services of \$988.68 divided by the sum of all APC payments is 100.00%. The sum of all packaged costs is \$1,575.77. The allocated portion of packaged costs is \$1,575.77. This amount added to the service cost yields a total cost of \$3,583.67. The cost of these services exceeds the annual fixed-dollar threshold of \$2,775. The amount by which the cost exceeds 1.75 times the OPSS payment is \$1,853.48. 50% of this amount is \$926.74. The total Medicare facility specific reimbursement amount for this line, including outlier payment, is \$1,915.42. This amount multiplied by 200% yields a MAR of \$3,830.84.

2. The total allowable reimbursement for the services in dispute is \$3,830.84. The amount previously paid by the insurance carrier is \$1,977.36. The requestor is seeking additional reimbursement in the amount of \$1,471.97. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$1,471.97.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$1,471.97 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

_____	_____	February ,2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.